STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155718		(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/10/2011		
		100710	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/10/20	J 1 1
NAME OF F	PROVIDER OR SUPPLIER			1	/EST CROSS STREET		
	NITY NORTHVIEW			ANDER	RSON, IN46011		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000		r a Post Survey Revisit	F00	00			
	` ′	ertification and State completed on 1/25/11.					
	Electistic survey	completed on 1/25/11.					
	Survey dates: M	farch 9 and 10, 2011					
	Facility number:	000562					
	Provider number	: 155718					
	AIM number: 10	00267150					
	Survey Team:						
	Toni Maley, BSV	W, TC					
	Donna M. Smith	, RN					
	Tammy Alley, R	N					
	Census Bed Type	e:					
	SNF: 4						
	SNF/NF: 73						
	Residential: 26						
	Total: 103						
	Census Payor Ty	pe:					
	Medicare: 18	_					
	Medicaid: 43						
	Other: 42						
	Total: 103						
	Sample: 11						
	These deflciencies a	also reflect state findings					
	in accordance with	410 IAC 16.2.					
	Quality review comp	pleted 3-15-11					
	Cathy Emswiller RN						
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIC			TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155718		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/10/2011	
	PROVIDER OR SUPPLIER		STREET A 1235 W	DDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	(PSR) to the Rec Licensure survey	:: 155718 00267150 W, TC , RN N				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155718			A. BUILDING	UNSTRUCTION	COMP	COMPLETED 03/10/2011	
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE			
	PROVIDER OR SUPPLIER		1235 W	EST CROSS STREET			
COMMU	NITY NORTHVIEW	CARE CENTER	ANDER	RSON, IN46011		-	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	TON D BE	(X5) COMPLETION	
TAG	· ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE	
	These deflciencies a	also reflect state findings					
	in accordance with	410 IAC 16.2.					
	Quality review com	pleted 3-15-11					
	Cathy Emswiller RN						
				!			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPLETED
		155718	B. WIN			03/10/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE /EST CROSS STREET	
COMMUI	NITY NORTHVIEW	CARE CENTER		l	RSON, IN46011	_
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
F0315	5.) Reside		F03		The plan of correction for F 31 will be to ensure that all reside	5 04/09/2011
SS=E	record was review on				who have an indwelling cathet have the proper catheter care	er
	3/9/11 at 2	2:45 p.m.			to prevent infections. The facil will ensure that residents #61,#45,#2,and #18 will be	
	Resident #	#18's current			monitored closely during tranfe to prevent the possibility of infections. Before the facility recieved the 2567 every nursing	
	diagnoses	included, but			employee was educated on ho to transfer a resident with a	
	were not 1	imited to,			catheter. The employee was the	nen
	Alzheime	r's disease and			responsible for completing a return demonstration in front o	f
	Parkinson	's disease.			their supervisor proving their competence with this skill. This	s
	Resident # current 2/2 physician' anchored Resident # history of infections recently e	ent #18 had a ent 2/20/11, cian's order for an red catheter. ent #18 had a y of urinary tract ions and was most cly evaluations and nent for a urinary			was completed by April 25th 2011. Since receiveng the 256 the facility has called in a Cert Clinical Nurse Specialist to tra all employees on . The Nurse specialist will meet with the fact on the 28th of March and is planning to complete 3 inserving at the facility on April 4,5, and 6 The documentation proving evidence of this directed in-service training will be sent the ISDH as verification of completion by April the 11th, 2011. The facility will continue (after all nursing employees are trained) to mandate that employees pass return demonstration compete in order to remain an employe Community Northview Care center. The Facility will Provide competencies regarding cather	ified in sility ces 6. to the ncy e of e

000562

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155718	B. WING			03/10/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IN46011				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	tract infections: a.) A 2/17 culture and with a rest tract infection greater that gram negations and tablet two 10 days for of a urinary infection. On 3/09/1 a.m. to 10	tion as /11 urine d sensitivity ult of a urinary tion with an 100,000 ative bacilli. /11- Bactrim tibiotic)-1 times daily for or the treatment ry tract 1 from 10:20 ::45 a.m.,		- 1	placement and transfers every months. All New employees w be trained on this deficiency before they are able to work at Community Northview Care Center. The Director of Nursin will be responsible for keeping documentation regarding this deficiency and will ensure that nursing staff are trained proper and timely. The DON will be responsible for providing and reporting on the progress of the deficiency at our QA meetings. The facilities RN supervisors will continue to specheck 5 employees a week in order to ensure this deficient practice does not recurr. All documentatin will be given to the DON regarding these 10 spot checks weekly. This will be an ongoing process and will be completed by April 9, 2011	DATE DATE DATE DATE DATE DATE	
	Resident #	#18 personal					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155718	A. BUI B. WIN			03/10/2	011	
NAME OF I	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE EST CROSS STREET	•		
COMMU	NITY NORTHVIEW	CARE CENTER		1	SON, IN46011			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	care and t	ransfer were						
	observed.							
	completin	g the shower						
	and dressi	ng the						
	resident, (CNA #7 was						
	observed '	to hook the						
	resident's Foley catheter							
	(F/C) bag onto her arm							
	positionin	g it above the						
	resident's	urinary						
	bladder.	Yellow urine						
	with white	e sediment was						
	observed	in the F/C						
	tubing and	d bag. The						
	resident w	as then stood						
	up from th	ne shower chair						
	as CNA#	8 dried the						
	resident's	buttocks						
	before her	brief and						
	pants were	e pulled up.						

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155719		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE COMPI	
		155718	B. WIN				03/10/2	011
NAME OF I	PROVIDER OR SUPPLIE	3		1	.DDRESS, CITY, STATE, 2 EST CROSS STRE			
COMMU	NITY NORTHVIEW	CARE CENTER		1	SON, IN46011			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	Ē	(X5) COMPLETION DATE
	After the	resident was						
	transferre	d to her						
	wheelcha	ir, CNA #7						
	lowered t	he resident's						
	F/C bag b	elow her						
	bladder le	evel and hooked						
	it under th	ne resident's						
	wheelcha	ir. At this same						
	time durii	ng an interview,						
	CNA #7 i	ndicated she						
	knew the	F/C bag/tubing						
	was not to	touch the						
	floor or o	ne's uniform.						
	She indicate	ated the F/C						
	bag would	d touch one's						
	uniform v	when hung from						
	one's pocl	ket. She						
	indicated	she was not						
	aware the	F/C tubing/bag						
	should no	t be held above						
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	 7UY912	Facility I	D: 000562	If continuation sl	neet Pa	ge 7 of 29

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155718		A. BUILDING	ONSTRUCTION	(X3) DATE COMP 03/10/2	LETED			
	PROVIDER OR SUPPLIER		B. WING 03/10/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IN46011					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	the resider	nt's bladder.						
		ral tag was /25/11. The						
	facility fa							
	_	t a systemic						
	_	rrect to prevent						
	recurrence	2.						
	3.1-4(a)(2							

STATEMENT OF DEFICIENCIES (X1) PRO		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155718	B. WIN			03/10/2	011
			F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/EST CROSS STREET		
COMMUI	NITY NORTHVIEW	CARE CENTER	ANDERSON, IN46011				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0315	Based on record	review, observation, and	F03	15	The plan of correction for F 31		04/09/2011
SS=E	interview, the fac	cility failed to ensure			will be to ensure that all reside who have an indwelling cathet		
-	anchored cathete	r drainage bags and			have the proper catheter care		
	tubing were posit	tioned in a manner to			to prevent infections. The facil		
		bility of infection for 4 of			will ensure that residents	,	
	• •	wed with anchored			#61,#45,#2,and #18 will be		
		nple of 11. (Resident #			monitored closely during tranfe	ers	
		-			to prevent the possibility of		
	61, # 45, # 2, and	1# 10)			infections. Before the facility		
					recieved the 2567 every nursing employee was educated on ho		
	Findings include				to transfer a resident with a	, v v	
					catheter. The employee was the	nen	
	1. A May 2002 p	policy titled "Anchored			responsible for completing a		
	Catheter Care" w	as provided by the			return demonstration in front o	f	
	Director of Nursi	ing on 3/10/11 at 10:20			their supervisor proving their		
	a.m., and deemed	d as current. The policy			competence with this skill. This	S	
	·	Urinary drainage bag			was completed by April 25th 2011. Since receiveng the 256	7	
		w the bladder to assure			the facility has called in a Cert		
	_	ow form the bladder.			Clinical Nurse Specialist to tra		
	•	ouching the floor"			all employees on . The Nurse		
	Secure to avoid t	ouching the moor			specialist will meet with the fac	cility	
	2 F1 1.0	D :1			on the 28th of March and is		
		or Resident # 61 was			planning to complete 3 inserving at the facility on April 4,5,and 6		
	reviewed on 3/9/	11 at 11:25 a.m.			The documentation proving	J	
					evidence of this directed		
	Current diagnose	es included, but were not			in-service training will be sent	to	
	limited to urinary	retention.			the ISDH as verification of		
					completion by April the 11th,		
	Current physician	n orders for March 2011			2011.The facility will		
		er for an anchored			continue(after all nursing employees are trained) to		
	catheter.				mandate that employees pass	the	
					return demonstration compete		
	A Dhygiaian anda	er dated 2/8/11 indicated			in order to remain an employe	-	
	_				Community Northview Care		
		nalysis with a culture and			center. The Facility will Provide		
	sensitivity.				competencies regarding cathe	ter	
			1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155718 03/10/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1235 WEST CROSS STREET COMMUNITY NORTHVIEW CARE CENTER ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE placement and transfers every 6 months. All New employees will A nursing note dated 2/9/11 at 12:16 p.m., be trained on this deficiency indicated 100 milliliters of cloudy urine before they are able to work at was obtained for the above test. Community Northview Care Center. The Director of Nursing will be responsible for keeping all A 2/11/11 final lab report indicated the documentation regarding this resident had Escherichia Coli and Gram deficiency and will ensure that all Negative Bacilli in his urine. nursing staff are trained properly and timely. The DON will be responsible for providing and A 2/12/11 physician order indicated an reporting on the progress of this order to monitor temp for 72 hours, give 4 deficiency at our QA ounces of cranberry juice with each meal meetings. The facilities RN and 4 ounces of water each shift. supervisors will continue to spot check 5 employees a week in order to ensure this deficient During an observation on 3/9/11 at 11:15 practice does not recurr. All a.m., Resident # 61 was transferred to the documentatin will be given to the DON regarding these 10 spot toilet by CNA # 1. She began the transfer checks weekly. This will be an by unhooking the anchored catheter bag ongoing process and will be from under the wheelchair and placed the completed by April 9, 2011 bag and tubing on the floor under the wheelchair. There was urine in the bag and tubing. She then hooked the anchored bag onto the arm of the wheelchair, stood the resident up and transferred him to the toilet. During the transfer the catheter tubing began to pull, CNA # 1 then tossed the anchored catheter bag and tubing onto the floor beside the toilet. After several minutes, the CNA then picked up the anchored catheter bag and hung it on the footrest of the wheelchair, with the drainage bag touching the floor. She transferred the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION	(X3) DATE S COMPL		
		155718	B. WIN			03/10/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	•	
COMMU	NITY NORTHVIEW	CADE CENTED		1	EST CROSS STREET SON, IN46011		
			_		.30N, IN400TI		71.E
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	resident to the w	heelchair and then					
	transferred him to	o his bed. When					
	completed she hooked the anchored						
	_	bag to the bed frame					
	with the drainage	e bag touching the floor.					
	During an intervi	iew on 3/9/11 at 11:40					
	_	dicated she was aware					
	*	anchored catheter					
	•	tubing on the floor 2					
		ated the drainage bag and					
		supposed to be placed or					
	let touch the floo	r.					
		r Resident # 45 was					
	reviewed on 3/9/	11 at 1:45 p.m.					
	Current physicia	n orders for March 2011					
		er for an anchored					
	catheter.	101 WII WII WII 01 0 W					
	A 12/9/10 urinaly	ysis and culture and					
	_	ted the resident had					
	Gram Negative I	Bacilli in her urine.					
	A 10/17/10 -4 7:/	15 m ma managing state					
		45 p.m., nursing note dent was started on					
		grams (antibiotic) three					
		urinary tract infection.					
	annos a day 101 a	armary muct infection.					
	During an observ	vation on 3/9/11 at 11:10					
	_	45 was in her room in her					
	wheelchair with	her anchored catheter					

000562

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO LDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155718	B. WIN			03/10/2	011
NAME OF F	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
COMMUI	NITY NORTHVIEW	CARE CENTER			SON, IN46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		the floor under the					
	wheelchair. At the	•					
	interview, CNA # 3 indicated the catheter						
	•	ng the clip so she had					
	been unable to cl						
	4. The record for	r Resident # 2 was					
ı	reviewed on 3/9/	11 at 12 p.m.					
	Current physicia	n orders for March 2011					
		er for an anchored					
	catheter.						
	During an observ	vation on 3/9/11 at 10					
	-	2 was transferred by					
		er wheelchair to her bed.					
	-	d the anchored catheter					
		eelchair and placed it on					
	-	ne resident's chair. There					
		drainage bag and tubing.					
		nt was lifted up in the					
		ge bag was place on the					
	-	the level of the bladder.					
	110,01 1111 400 10 1	and let of the olumber.					
	During an intervi	iew on 3/9/11 at 10:05					
	_	dicated she was aware					
		drainage bag and tubing					
	_	e indicated she was					
		out the drainage bag					
	during a hoyer tr						
		······································					

PRINTED: 04/06/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE : COMPL 03/10/2	ETED
	ROVIDER OR SUPPLIER		P. (12)	STREET A	ADDRESS, CITY, STATE, ZIP CODE /EST CROSS STREET RSON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0315 SS=E			F03	15	The plan of correction for F 31 will be to ensure that all reside who have an indwelling cathet have the proper catheter care to prevent infections. The facil will ensure that residents #61,#45,#2,and #18 will be monitored closely during tranfet to prevent the possibility of infections. Before the facility recieved the 2567 every nursing employee was educated on to transfer a resident with a catheter. The employee was the responsible for completing a return demonstration in front of their supervisor proving their competence with this skill. This was completed by April 25th 2011. Since receiveng the 256 the facility has called in a Cert Clinical Nurse Specialist to transfer all employees on . The Nurse specialist will meet with the fact on the 28th of March and is planning to complete 3 inserving at the facility on April 4,5, and 6 The documentation proving evidence of this directed in-service training will be sent the ISDH as verification of completion by April the 11th, 2011. The facility will continue (after all nursing employees are trained) to mandate that employees pass return demonstration compete in order to remain an employe Community Northview Care center. The Facility will Provid competencies regarding cather centers are supplementation cather that employees are trained to mandate that employees pass return demonstration compete in order to remain an employe Community Northview Care center. The Facility will Provid competencies regarding cather	ents er as e	04/09/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7UY912 Facility ID:

000562

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155718		(X2) MULTIPLE CO A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 03/10/2011	
	PROVIDER OR SUPPLIER		STREET A 1235 W	ADDRESS, CITY, STATE, ZIP CODE VEST CROSS STREET RSON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	O BE	(X5) COMPLETION DATE
				placement and transfers e months. All New employed be trained on this deficient before they are able to wo Community Northview Car Center. The Director of Nu will be responsible for kee documentation regarding the deficiency and will ensure nursing staff are trained properties and timely. The DON will be responsible for providing a reporting on the progress deficiency at our QA meetings. The facilities RN supervisors will continue to check 5 employees a wee order to ensure this deficient practice does not recurr. A documentatin will be given DON regarding these 10 schecks weekly. This will be ongoing process and will be completed by April 9, 2011	es will cy rk at re ursing ping all this that all roperly e and of this o spot k in ent all i to the pot e an oe	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155718	B. WIN			03/10/2011	
NAME OF F	ROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					EST CROSS STREET		
COMMUI	NITY NORTHVIEW	CARE CENTER		ANDER	RSON, IN46011	_	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	, and the second se	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETIC DATE	ON
F0328		· · · · · · · · · · · · · · · · · · ·	F03		the plan of correction for F328		11
SS=D	Resident 7	#61's record	105	20	be to ensure residents #50 and	d 0 1/ 0 2/ 20	11
00 5	was revie	wed on 3/9/11			#61 have their oxygen set at the flow rate as ordered by a	ie	
	at 11:25 a	m			physician. Resident #50 and #		
	dt 11.23 d.m.				will have their flow rates check and documented daily until Ap		
					9th 2011. Every other resident		
	Resident #61's current				recieving oxygen will also have	Э	
	Resident 1	401 S Current			their flow rates checked and verified daily until April 9th 201	1	
	diagnoses	included, but			The facility will then complete		
		,			weekly spot checks ongoing to		
	were not l	limited to,			ensure that this does not recu	r.	
	hypoxia, o	chronic			The spot checks will be documented and obtained by	he	
	•				DON for review and		
	obstructiv	e pulmonary			completion.The directed inserv		
	disease ar	nd Alzheimer's			training regarding this deficien will take place on April 4th, 5th	- 1	
					and 6th. The training is be;ing		
	disease.				completed by a Certified Clinic	al	
					Nurse Specialist hired by the facility to train our nursing		
					staff. The imformation rewgard	ling	
	Resident #	#61 had a			this training will be sent to The		
	1/14/11, c	ourrent			ISDH by april the 11th 2011.As part of our new hire orientation		
		,			nursing staff will recieve our		
	physician	's order for			policy and traing on o2 administration.The oxygen flow	v	
	oxygen to	be			rate will be documented on the CNA assignment sheets daily	l l	
	administe	red at a flow			help remind them to check and		
					notify a Nurse if oxygen is not		
	rate of 3 l	iters a minute			correct.The DON will be responsible for providing all		
	per nasal canula.				documentaion at the QA meet	·	
					for review and changes. The P	lan	
					of correction date for this deficiency is April 9th 2011.		

000562

	155718	A. BUILDIN	NG		03/10/2	
	1007 10	B. WING	TREET A	DDRESS CITY STATE 7ID CODE	03/10/2	011
ER OR SUPPLIER						
NORTHVIEW	CARE CENTER	A	NDER	SON, IN46011		
EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	PRI	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
sident #	61 had a					
current 1/25/11, care						
an probl	em regarding					
e resider	nts need for					
oxygen therapy due to						
chronic obstructive						
pulmonary disease. An						
approach to this problem						
is to adr	ninister					
ygen at	a 3 liter flow					
e.						
n 3/9/11	at 11:05 a.m.,					
sident #	² 61 was					
served s	seated in his					
neelchai	r with a					
rtable of	xygen tank in					
ace. The	e flow rate on					
e portab	le oxygen tank					
is set at	2 liters.					
	summary streach deficience egulatory or in esident # rent 1/2 in proble resider ygen the ronic oblimonary proach the sto adrigation at the esident # served streached in the elichair resident # served streached in the elichair residence. The exportable of the portable	ER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PERCEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) Esident #61 had a rrent 1/25/11, care an problem regarding e residents need for ygen therapy due to ronic obstructive Ilmonary disease. An proach to this problem as to administer ygen at a 3 liter flow	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PERCEDED BY FULL ESGULATORY OR LSC IDENTIFYING INFORMATION) ESIGENT #61 had a Frent 1/25/11, care In problem regarding E residents need for Tygen therapy due to Tronic obstructive Ilmonary disease. An Typroach to this problem The sto administer Tygen at a 3 liter flow Tygen at a 3 liter flow Tygen the second in his Tygen the second in his Tygen at a 3 liter flow Tygen at a 4 liter flow Tygen at a 4 liter flow Tygen at a 5 liter flow Tygen at a 5 liter flow Tygen at a 5 liter flow Tygen at a 6 l	STREET A 1235 W ANDER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PERCEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) PSIDE THE STREET A 1235 W ANDER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PERCEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG TO PREFIX TAG TAG TO PREFIX TAG TAG TAG TAG TAG TAG TAG TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IN46011 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SIGNATIVE WILLS BE PERCEDED BY FULL BEQULATORY OR LSC IDENTIFYING INFORMATION) SIGNATIVE WILLS BE PERCEDED BY FULL BEQULATORY OR LSC IDENTIFYING INFORMATION) SIGNATIVE WILLS BE PERCEDED BY FULL BEQULATORY OR LSC IDENTIFYING INFORMATION) SIGNATIVE WILLS BE PERCEDED BY FULL BEQULATORY OR LSC IDENTIFYING INFORMATION) SIGNATIVE WILLS BE PERCEDED BY FULL BEQULATORY OR LSC IDENTIFYING INFORMATION) TAG TO STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IN46011 BY PREFIX TAG FRACTION SINGUID BE CROSS-REFERENCED TO THE APPROPRIA TAG TO STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IN46011 BY PREFIX TAG FRACTION SINGUID BE CROSS-REFERENCED TO THE APPROPRIA TAG TO STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IN46011 BY PREFIX TAG FRACTION SINGUID BE CROSS-REFERENCED TO THE APPROPRIA TAG TO STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IN46011 FREFIX TAG FRACTION SINGUID BE CROSS-REFERENCE TO THE APPROPRIA TAG TO STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IN46011 FREFIX TAG FRACTION SINGUID BE CROSS-REFERENCE TO THE APPROPRIA TAG TO STATE AND CROSS CITY, STATE TAG TAG TO STATE AND CROSS CITY, STATE TAG TAG TAG TAG TAG TAG TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, INA6011 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PERCEDED BY FULL BEGULATORY OR LSC IDENTIFYING INFORMATION) SIGNET 1/25/11, care an problem regarding the residents need for tygen therapy due to tronic obstructive Ilmonary disease. An proach to this problem as to administer tygen at a 3 liter flow the company of the com

AND PLAN OF CORRECTION IDENTIFICATION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155718	A. BUI B. WIN	LDING IG		03/10/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE EST CROSS STREET		
COMMUI	NITY NORTHVIEW	CARE CENTER		ANDER	SON, IN46011		_
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTF	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 3/0/11	at 11:20 a m					
	On 3/9/11 at 11:20 a.m.,						
	Resident #						
		receiving care					
	in his rooi	n with the					
	portable oxygen tank in						
	place. The oxygen flow						
	rate continued to be set						
	at 2 liters.	During an					
	interview	at this time					
	LPN #4 in	ndicated the					
	residents of	oxygen was set					
	at the inco	orrect flow rate					
	and should	d be set at 3					
	liters as or	rdered.					
	This Fede	ral tag was					
	cited on 1	/25/11. The					
	facility fai	iled to					
	_	t a systemic					
	F 3						

l	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COME	(X3) DATE SURVEY COMPLETED 03/10/2011	
	PROVIDER OR SUPPLIER		1235 W	ADDRESS, CITY, STATE, ZIP COL VEST CROSS STREET RSON, IN46011	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	plan of co	rrect to prevent					
	recurrence.						
	3.1-47(a)(

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155718	B. WING			03/10/2	011
			D. WIIW		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				VEST CROSS STREET		
COMMUI	NITY NORTHVIEW	CARE CENTER			RSON, IN46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0328	Based on record	review, observation and	F032	28	the plan of correction for F328		04/09/2011
SS=D	interview, the fac	cility failed to ensure			be to ensure residents #50 and		
00 5	oxygen was set a	t the physician ordered			#61 have their oxygen set at the flow rate as ordered by a	ie .	
		4 residents reviewed for			physician. Resident #50 and #	61	
		ration in a sample of 11.			will have their flow rates check		
		_			and documented daily until Ap		
	(Resident # 50 and # 61)				9th 2011. Every other resident		
					recieving oxygen will also have	е	
					their flow rates checked and		
	Findings include: 1. The record for Resident # 50 was reviewed on 3/9/11 at 3 p.m.				verified daily until April 9th 201	1.	
					The facility will then complete weekly spot checks ongoing to	,	
					ensure that this does not recur		
					The spot checks will be	١.	
		•			documented and obtained by t	:he	
	Current diagnose	es included, but were not			DON for review and		
	limited to, pneum				completion.The directed inserv		
	minica to, pricuri	iloina.			training regarding this deficien		
	G . 1	1 6 14 1 2011			will take place on April 4th, 5th	1	
		n orders for March 2011			and 6th. The training is be;ing completed by a Certified Clinic	val	
		er for oxygen to be			Nurse Specialist hired by the	aı	
	administered at 2	liters.			facility to train our nursing		
					staff. The imformation rewgard	ling	
	During the initial	1 tour on 3/9/11 at 9:15			this training will be sent to The		
	a.m., RN # 5 che	cked the flow rate of			ISDH by april the 11th 2011.As		
		kygen on her portable			part of our new hire orientation	ı all	
		he was sitting in the			nursing staff will recieve our		
		n 2 liters. The RN then			policy and traing on o2 administration. The oxygen flow	.,	
		w rate should be 3 liters			rate will be documented on the		
					CNA assignment sheets daily		
	and changed the	flow rate to 3 liters.			help remind them to check and		
					notify a Nurse if oxygen is not		
	_	vation on 3/9/11 at 3:30			correct.The DON will be		
	p.m., Resident #	50 was in her room. Her			responsible for providing all		
	concentrator was set at 3 liters. At that time LPN # 6 indicated the flow rate should have been 2 liters and changed the				documentaion at the QA meeti for review and changes. The P		
					of correction date for this	iaii	
					deficiency is April 9th 2011.		
	flow rate to 2 lite	_					
	110 11 Tate to 2 Inte				1		

000562

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/10/2011	
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
	NITY NORTHVIEW		1235 WEST CROSS STREET ANDERSON, IN46011				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
F0363 SS=D	Based on	observation,	will be		will be to ensure that resident #30		04/09/2011
00-B	interview and record				recieves the proper diet. The Dietician has been in and reviewed and made the proper	_	
review, the facility failed				changes (per Physicians Orde to ensure that this resident			
	to ensure	a resident who			recieves the proper diet.In orde		
	had a phys	sician's order			to ensure that all other resident recieve the proper diet the faci	lity	
	for a low potassium diet				reviewed every diet in the facil and will continue to review tho		
	had a men	u developed			on a weekly basis during our Nutrition at risk weekly meeting	g.	
	and served for 1 of 1				The facility dietician will also review every diet in the buildin	g	
	resident w				on weekly visits to ensure the facility offers and maintains that		
		diet order in a			diet.All staff willbe trained on the diets the faacility offersand a li	ne	
	•				will be maintained in the Nur;s	ing	
	_	11 (Resident			and Dietary Department of the facilities. The admission nurse		
	#30).				also have a list of the diets offered in order to ensure that		
					diet is ordered will be given.Sing all staff might pass trays in the		
	Findings i	nclude:			dining room the Directed in-service training will be giver	ı to	
					all staff in the building. The foo	d	
	1.) A revi	ew of a			at least 2 meals weekly to ens the proper diets are being serv	ure	
	current, u	ndated, facility			This information will be documented and given to the	Ju.	
	menu for	3/9/11 and			administrator for review on a	1	
					training and checks will be		
	,				changes.The facility will train a new employees on how to rea	ıll	
	menu for 3/9/11 and 3/10/11, which was provided by the				weekly basis. The results of al training and checks will be provided at our QA for review a changes. The facility will train a	and Ill	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE S COMPL	
		155718	A. BUI B. WIN	LDING IG		03/10/20	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE /EST CROSS STREET		
COMMUI	NITY NORTHVIEW	CARE CENTER		ANDEF	RSON, IN46011		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	and understand diet orders to		DATE
		ator on 3/9/11			help ensure that all staff is trained. The plan of correction for		
	at 11:10 a.m., lacked any menu for a low potassium diet.			this ongoing process will be a 9th 2011.			
					9012011.		
	2.) During a 3/9/11,						
	11:30 a.m., to 12:00						
	p.m., lunch meal						
	observation	on, Cook #2					
	was obser	ved serving a					
	meal to Re	esident #30.					
	Resident #	#30's meal card					
	indicated	the resident					
	had a phys	sician's order					
	for a no co	oncentrated					
	sweets, lo	w potassium					
	diet. Duri	ing an					
	interview	at that time,					
	Cook #2 i	ndicated the					
	facility die	d not have a					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	A. BUI	LDING	NSTRUCTION	(X3) DATE: COMPL 03/10/2	ETED
NAME OF I	PROVIDER OR SUPPLIER		B. WIN		DDRESS, CITY, STATE, ZIP CODE	03/10/2	V 1 1
	NITY NORTHVIEW			1	EST CROSS STREET SON, IN46011		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
		enu for a low					
	potassium diet. She						
	indicated	she had a copy					
	of an old 1	menu which					
	she used t	o decide what					
	to serve the resident.						
	Cook #2 served Resident						
	#30 the following:						
	a.) 3 ound beef with	ces of roast out gravy					
		ces of cooked thout butter.					
	juice, whi indicated serving as	ces of tomato ch Cook #2 she was a substitute es which the					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	A. BUILDI		NSTRUCTION	(X3) DATE S COMPL 03/10/2	ETED
	PROVIDER OR SUPPLIER		1	235 W	DDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011	1 22 10/2	- •
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	resident co	ould not have.					
	d.) a slice bread	e of wheat					
	e.) no sugar added baked apples topped with cinnamon.						
	3:05 p.m., Food Serv Superviso facility die current me potassium indicated	r indicated the d not have a enu for a low diet. She the facility had ed "Foods					

NAME OF PROVIDER OR SUPPLIER 155718 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	
COMMUNITY NORTHVIEW CARE CENTER 1235 WEST CROSS STREET ANDERSON, IN46011	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	(X5) COMPLETION DATE
which was in the kitchen	
at the time of the 3/9/11	
lunch service. She	
indicated the form had	
been moved to the far	
side of the room in error.	
She indicated although	
the facility did not have	
a menu for low	
potassium diets the cook	
should have used the	
form for guidance when	
serving Resident #30's	
diet.	
4.) Review of an	
undated, current facility	
form titled "Foods High	
in Potassium", which	
was provided by the	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION	(X3) DATE S	
		155718	B. WIN			03/10/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
COMMUI	NITY NORTHVIEW	CARE CENTER			EST CROSS STREET SON, IN46011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Food Serv	vices					
	Superviso	r on 3/9/11 at					
	3:05 p.m.,	indicated the					
	following items were						
	"Potassium Rich Foods"						
	a.) apples	1					
	a.) apples						
	b.) meats						
	o.) means						
	c.) carrots	S					
	,						
	d.) wheat	bread					
	,						
	e.) tomato	oes					
	<i>,</i>						
	5.) Resido	ent #30's					
	clinical re						
	reviewed	on 3/9/11 at					

AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	A. BUILDING	CONSTRUCTION	СОМ	E SURVEY PLETED /2011		
NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER			B. WING 03/10/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IN46011					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	2:40 p.m.							
		#30's current						
	diagnoses included, but were not limited to,							
	diabetes and expressive							
	aphasia.							
	Resident #30 had a current, 4/7/10, physician's order for a no concentrated sweets, low potassium diet.							
	plan problerelated to	/16/11, care lem/need high potassium approach to						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/10/2011	
NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IN46011				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	serve a de	creased					
	potassium	diet.					
	Resident #	#30 had a,					
	2/14/11, p	otassium					
	laboratory	blood test,					
	which indicated the resident had a high potassium of 5.2 with a normal range being 3.6 to 5.0.						
	This Fede	ral tag was					
	cited on 1/25/11. The facility failed to implement a systemic						
	*	rrect to prevent					
	recurrence	•					

AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/10/2011			
NAME OF PROVIDER OR SUPPLIER COMMUNITY NORTHVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IN46011					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION			
R0000	3.1-20(i)(3.1-20(i)(1) 4)	R0000					

PRINTED: 04/06/2011 FORM APPROVED OMB NO. 0938-0391

ſ	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
l	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING		COMPLETED		
			155718			03/10/2011		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IMAGO11					
COMMUNITY NORTHVIEW CARE CENTER				ANDERSON, IN46011				
I	(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
l	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
l	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7UY912

Facility ID: 000562

If continuation sheet